STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
SOCIAL HISTORY SUMMARY FOR THE DISABLED

______________________County Department of Social Services Date_______________

Claimant ____________________________________ SSN ___________________________

County Case # ________________________________ District # ________________________

Telephone # or a number you can be reached ______________________________________

Person Providing Information and Telephone # (if different from claimant)

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Nature of Disability (based on claimant's description or statement)

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I. Onset of Impairment

A. Date of illness or injury began____

B. Date claimant stopped work ____

C. Date the illness or injury became disabling____

D. If still working:

Name of Employer ____

Supervisor's name and telephone #____

Hours worked ____

Gross earnings ____________ weekly __________ monthly ___________________________

II. Claimant's Description of Impairment

A. Indicate how the claimant describes the symptoms of the disability and how they affect his ability to work.

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B. Describe claimant's daily activities and explain how the impairments affect him such as seeing, hearing, speaking, reading, walking, writing, standing, breathing, sitting, using hands, arms, and other joints. Describe how his impairments limit what he can do.

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C. Worker's Observation of Difficulties

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III. Vocational Information (include self employment)

A. Principal Job (job done the longest in 15 years prior to onset)

1. Job Title ____________________ 4. Hrs. /day __________
2. Industry ____________________ 5. Days/week __________
3. Beginning date ____________________ 6. Rate of pay/average earnings

Ending date ____________________ $________per __________

Other Jobs – List of jobs done in last 15 years prior to alleged onset date. Give approximate dates of employment (use additional sheet if necessary)

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B. Education/Highest Grade Completed ____________________

High School Graduate?____________________

Name and address of school if known ____________________

Additional education _____ Type __________ Is claimant currently attending school?________

Name of school and address if known ____________________

Can claimant read and write? ____________________

IV. **List all Medical Sources (physicians, hospitals, emergency facilities, health departments, therapists, nursing homes, clinics, mental health centers**,) including names and dates seen in the last twelve months. Give hospital or clinic number, which is on hospital or clinic card or hospital bills. (Twelve months prior to and including application month, plus any future medical appointments)

Medical Source Name, Address, Ph. #	Condition Treated EKG, X-rays	Dates Seen at Dr.'s office, clinic, hospital

Is claimant still being treated? Yes ____ No ____

V. **VR Referral ___ Yes ___ No Date last seen ______________________**
VR Office ____
Counselor's Name ________________________Phone #______________

VI. **If a mental impairment is alleged, if there is evidence of drug or alcohol abuse or if the person is homeless, in a shelter or in a halfway house, please give name, address and phone number of someone who can be contacted as a third party.**

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Signature ____________________________

Title__________________________________

Telephone # __________________________